St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted] Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT MAX FACIAL WO/C
04/07/2017 259923

MAX FACIAL WO/C, 4/7/2017 9:25 PM, SHSM

INDICATION:
TACKLED BY POLICE/HIT FACE RM 2

ADDITIONAL CLINICAL INFORMATION:
Ordering Provider Reason for Exam:
Technologist Note:
Additional: None

COMPARISON:
None available at the time of dictation.

TECHNIQUE:
Maxillofacial CT performed with coronal and sagittal reformatted images.

IV CONTRAST:
FINDINGS:
No facial fracture is identified. There is superficial punctate metallic debris at the right orbit and along the right zygomatic arch soft tissues. Punctate metallic foreign bodies are also present adjacent to the anterior right globe. No post septal abnormality or post-septal foreign body is seen.

Globes appear intact.

There is evidence of previous right sinus surgery. Paranasal sinuses are clear.

Multiple dental caries are present. There is some erosive change of the right anterior maxilla with absence of maxillary teeth at this location. There are also absent mandibular teeth on the right.

IMPRESSION:

1. No facial fracture is identified

Exhibit 12

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT MAX FACIAL WO/C
04/07/2017 259923

2. Superficial metallic debris along the right cheek and adjacent to the right anterior globe.
3. Extensive periodontal disease with absent right-sided maxillary and mandibular teeth

See the Radiology Information System for this patient for the contrast type and quantity.

Electronically Signed By: Emily Norman, MD
Signed Date/Time: 4/7/2017 9:38 PM
Dictated from workstation: NCGSPACSD03
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/07/2017 **
Reported By: E. NORMAN M.D.
CC: R. MICKEVICIUS

Technologist: LARSON,KARI
Transcribed Date/Time: 04/07/2017 (2140)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/07/2017 (2140)

PLA 035

SMITH, THOMAS ID:30108417 07-APR-2017 21:08:32 Ministry Health Care-R.ED ROUTINE RECORD

31-JAN-1952 (65 yr)
Male Unknown

Room:2
Loc:812

Vent. rate	103	BPM
PR interval	120	ms
QRS duration	88	ms
QT/QTc	356/466	ms
P-R-T axes	73 -26	-18

Sinus tachycardia with Premature atrial complexes
T wave abnormality, consider inferior ischemia
Abnormal ECG
No previous ECGs available
Initial interpretation done at 21:08
Electronically signed by Mickevicius MD, Richard (10060) on 4/7/2017 10:48:02 PM

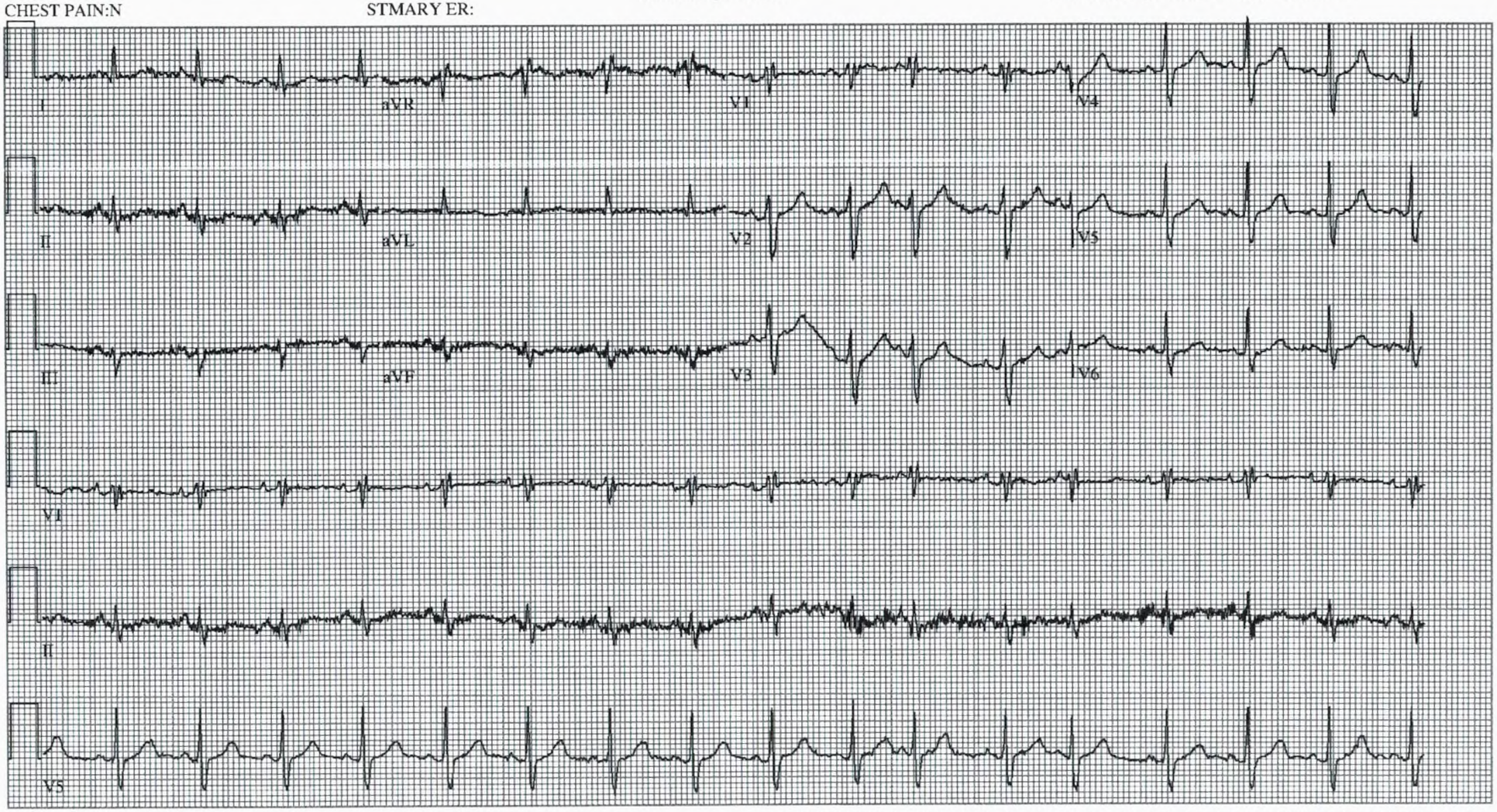
Technician: RLP
Test ind:ALTERED MENTAL STATU

Referred by: MICR

Confirmed By: Richard Mickevicius MD

CHEST PAIN:N

STMARY ER:



25mm/s 10mm/mV 40Hz 8.0 SP2 12SL 241 HD CID: 4

EID:10060 EDT: 22:48 07-APR-2017 ORDER:SMA0170407-0041M ACCOUNT: M00016934192

PLA 036

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT CERVICAL SPINE WO/C
04/07/2017 259923

INDICATION: Trauma

COMPARISON: No prior studies are available.

TECHNIQUE: Axial CT images were obtained of the cervical spine without IV contrast. Sagittal and coronal reformatted images were obtained. Automated exposure control was utilized for patient dose reduction.

FINDINGS: Cervical spine demonstrates normal alignment on both the sagittal and coronal reconstructed images.. There is no fracture or subluxation. Facet joints demonstrate normal alignment. C1-2 alignment is anatomic. There is no soft tissue swelling. The apical lung regions demonstrate no pneumothorax.

IMPRESSION:

1. No acute findings of the cervical spine.

Electronically Signed By: Emily Norman, MD
Signed Date/Time: 4/7/2017 9:33 PM
Dictated from workstation: NCGSPACSD03
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/07/2017 **
Reported By: E. NORMAN M.D.
CC: R. MICKEVICIUS

Technologist: LARSON,KARI
Transcribed Date/Time: 04/07/2017 (2135)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/07/2017 (2135)

PLA 037

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT HEAD WO/C
04/07/2017 259923

HEAD WO/C, 4/7/2017 9:25 PM, SHSM

INDICATION:
TACKLED TO GROUND/HIT HEAD RM 1

ADDITIONAL CLINICAL INFORMATION:
Ordering Provider Reason for Exam:
Technologist Note:
Additional: None

COMPARISON:
1/16/2017

TECHNIQUE:
Noncontrast CT brain was performed utilizing standard protocol. Images are reviewed in bone and soft tissue windows

FINDINGS:
The ventricles and sulci are normal in size and configuration for the patient's age. There is no intracranial hemorrhage, mass effect or midline shift. Brain parenchyma is normal in attenuation.

Visualized portions of paranasal sinuses and mastoid air cells appear clear.
IMPRESSION:
No intracranial hemorrhage or other acute abnormality by CT.
Electronically Signed By: Emily Norman, MD

Signed Date/Time: 4/7/2017 9:32 PM
Dictated from workstation: NCGSPACSD03
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/07/2017 **
Reported By: E. NORMAN M.D.
CC: R. MICKEVICIUS

Technologist: LARSON,KARI
Transcribed Date/Time: 04/07/2017 (2133)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/07/2017 (2133)

PLA 038

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]/1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT HEAD WO/C
04/07/2017 259923

HEAD WO/C, 4/7/2017 9:25 PM, SHSM

INDICATION:
TACKLED TO GROUND/HIT HEAD RM 1

ADDITIONAL CLINICAL INFORMATION:
Ordering Provider Reason for Exam:
Technologist Note:
Additional: None

COMPARISON:
1/16/2017

TECHNIQUE:
Noncontrast CT brain was performed utilizing standard protocol. Images are reviewed in bone and soft tissue windows

FINDINGS:
The ventricles and sulci are normal in size and configuration for the patient's age. There is no intracranial hemorrhage, mass effect or midline shift. Brain parenchyma is normal in attenuation.

Visualized portions of paranasal sinuses and mastoid air cells appear clear.
IMPRESSION:
No intracranial hemorrhage or other acute abnormality by CT.
Electronically Signed By: Emily Norman, MD

Signed Date/Time: 4/7/2017 9:32 PM
Dictated from workstation: NCGSPACSD03
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/07/2017 **
Reported By: E. NORMAN M.D.
CC: R. MICKEVICIUS

Technologist: LARSON,KARI
Transcribed Date/Time: 04/07/2017 (2133)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/07/2017 (2133)

PLA 039

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ICU 2252-A
Patient Status: ADM IN
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

RAD CHEST 1 VIEW PORT
04/07/2017 259923

CLINICAL HISTORY: Altered mental status.

COMPARISON: 3/20/2015.

FINDINGS: Heart size is normal. Lungs appear hypoinflated. Mild interstitial opacities present in both lungs could be related to a component of interstitial pulmonary edema. Airspace opacities noted in both lung bases could be related to atelectasis, aspiration or developing pneumonia. No definite pleural effusion or pneumothorax is evident. Air-filled bowel loops present in the upper abdomen.

IMPRESSION:
1. Hypoinflated lungs with increased interstitial opacities may be related to a component of interstitial pulmonary edema versus atelectasis from hypoinflation.
2. Airspace opacities in both lung bases could be related to atelectasis, aspiration or developing pneumonia.
Internal Use: Taken: 4/7/2017 9:30 PM

Electronically Signed By: Anthony Rutkowski M.D.
Signed Date/Time: 4/8/2017 7:24 AM
Dictated from workstation: NRIMRADID19
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/08/2017 **

Reported By: A. RUTKOWSKI M.D.
CC: R. MICKEVICIUS

Technologist: GRANT,KATHLEEN
Transcribed Date/Time: 04/08/2017 (0725)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/08/2017 (0726)

PLA 040

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate: [redacted]1952
Emergency Department Note Hosp
Service: 04/07/2017
Richard F Mickevicius MD

Printed: 01/10/18
At: 10:55

*** COPY ***

Patient seen 4/7/17.

FINAL IMPRESSION:
1. Hyperosmolarity.
2. Hyperglycemia.
3. Dehydration.
4. Leukocytosis.
5. Altered mental status.
6. Closed-head injury.
7. Contusions.
8. Abrasions.

Chief Complaint
Altered mental status.

History of Present Illness
The patient is a 65-year-old man who apparently called in through a TTY phone about shots being fired and bombs being rigged. A SWAT team was involved. Eventually the patient was placed in custody. In the process of doing so he was tackled to the ground. He sustained some abrasions. He was brought in to be evaluated. He himself does not communicate well. He communicates through writing. He apparently has not had any fevers, vomiting, diarrhea, chest pain, shortness of breath currently. Complained of some pain where he was struck. He had some chest pain previously. No urinary complaints. We do not know about medical compliance.

Past Medical History
1. Hypertension.
2. Asthma.
3. Gastroesophageal reflux disease.
4. Degenerative joint disease.
5. Diabetes type 2.
6. Microalbuminuria.
7. Allergic rhinitis.
8. Appendectomy.
9. Trigger finger release.
10. Bilateral carpal tunnel release.
11. Sinus surgery.
12. BPH.
13. Elevated PSA.
14. Bulbar weakness.
15. Severe dysarthria.

Medications
Please see his reconciled list, but they include:
1. Acetaminophen.
2. Amlodipine.
3. Aspirin.
4. QVAR.
5. AccuCheks.
6. Chlorhexidine.
7. Finasteride.
8. NovoLog.
9. Irbesartan.
10. Omega-3 fatty acids.
11. Omeprazole.
12. Simvastatin.
13. Spironolactone.
14. Flomax.

Allergies
1. HYDROCHLOROTHIAZIDE.
2. VICTOZA.

Family History
Noncontributory.

Social History
No tobacco, alcohol or drug use. He is retired from Foster & Smith.

Review of Systems
Please see HPI for pertinent positives and negatives, otherwise unknown as patient did not respond to all our questions, only some of them.

Examination
VITAL SIGNS: Per nursing notes.
CONSTITUTIONAL/PSYCHIATRIC: Well-nourished, well-developed, elderly man, awake, alert, follows commands, but has difficulty speaking.
HEENT: Head is normocephalic. He sustained abrasions to the forehead on the right side of his face. Eyes, sclerae anicteric. Conjunctivae not injected. Pupils 2-3 mm, round, reactive to light. Extraocular movements are intact. Ears, nose, mouth and throat: External inspection of ears and nose shows no acute abnormality. Oropharyngeal examination, patient had some bleeding from his gums. He had what looked like was probably an avulsion to his right central maxillary incisor. He has severe dental caries. He had good jaw occlusion.
NECK: The patient was in a cervical collar. No bony crepitus, stepoffs or apparent tenderness.
BACK: No bony crepitus, stepoffs of apparent tenderness.
RESPIRATORY: Normal respiratory effort. Auscultation of the lungs revealed no wheezes, crackles,

gurgles or stridor.
CARDIOVASCULAR: Auscultation reveals regular rate and rhythm. No murmurs, gallops or rubs. Peripheral pulses were 2+ and symmetrical.
EXTREMITIES: No nontraumatic edema. He had abrasions to his arms and knees but was moving his extremities once he was uncuffed with 5/5 strength.
NEUROLOGIC: Facial movement intact and symmetrical. Tongue protrusion midline. Palate is upgoing. Sensation is intact to light touch in extremities times 4.

MEDICAL DECISION MAKING:
The patient presents with above complaint. His tetanus is technically up to date. He last received one in October of 2007. He was sent for scanning of his head, face and neck. He had no facial fractures. No fractures of the cervical spine. No intracranial hemorrhage or other acute abnormality by CT. Labs returned. White count was 20.3 thousand. Hemoglobin 17.6, platelets 204. Beta hydroxybutyrate was 0.7. AccuChek done at bedside was 563. Serum glucose was 559 with a BUN of 45, creatinine 1.27. Magnesium 1.5, total bili 1.3. Alk phos, ALT, AST were all normal. Troponin is less than 15. Acetaminophen is less than 2. Salicylate less than 1.7. Ethanol less than 20. TSH, free T4 were 0.9 and 1.5 respectively. Serum osmolality was 329 which is elevated, normal range being 282 to 305. INR is 1.2. PTT is 27. Chest x-ray was portable technique but it looks like he could have an infiltrate right lower lobe. Blood cultures, lactate, procalcitonin were ordered. The patient's EKG today showed sinus tachycardia, rate of 103, an occasional PAC. He has a lot of baseline artifact. I see no definite ST segment elevation or depression. No T-wave changes to suggest ischemia or injury. The computer called T-wave abnormality considering inferior ischemia but he has a lot of artifact. When we looked back to his previous EKGs, all the most recent ones have the same type of artifact and changes.

At this point I think the patient requires admission. He was started on a non-DKA insulin drip protocol. After cultures are obtained we will discuss with Dr. Tran administration of antibiotic.

Impression
Final impressions remain as dictated. In addition, will add: Rule out sepsis.

Richard Mickevicius, MD/rs
Emergency Medicine

Dictated: 04/07/2017 at 21:56
Transcribed: 04/07/2017 at 23:46

Electronically signed by Mickevicius, Richard F MD on 04/07/2017 23:54.

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate: [redacted]/1952
Hosp History and Physical
Service: 04/07/2017
Trung Tran DO

Printed: 01/10/18
At: 10:57

*** COPY ***

Document Dates
4/7/17

Chief Complaint
Hyperglycemia.

History of Present Illness
This 65-year-old, nonverbal, Caucasian male with a history of diabetes mellitus type 2, CKD stage 3, bulbar weakness secondary to CVA, Parkinsons, and diabetes mellitus type 2 is brought in to the emergency room after sustaining a closed-head injury. Apparently this patient is unable to speak and had some issues where he believed he was in distress. He does not have a TTY machine at home, attempted to call 9-1-1 and through a lot of miscommunication 9-1-1 dispatcher concluded there was some sort of shooting versus a bomb threat resulting in police cordoning off downtown Rhinelander.

According to patient's son, when patient emerged from his home, police thought he was the bomber/shooter suspect and proceeded to tackle and restrain this elderly man. He is unable to communicate verbally and was brought into the emergency room where it was discovered patient has hyperglycemia. Most of the history is obtained from his son since the patient is nonverbal and only able to communicate via written form. History is limited because of communication difficulties.

According to the son, primary care provider lowered the evening NPH to 18 units because of morning hypoglycemia. The patient has difficulty drawing up his own insulin and son questions if patient is able to administering insulin correctly. Patient's son says they are working to get Medicaid/Medicare coverage and additional assistance.

Patient has been seeing a speech therapist due to dysphagia issues. There is suspicion patient is silently aspirating per speech therapist's note. The patient has been losing approximately 7-8 pounds per week due to poor appetite. Patient denies any fevers, chills or body aches by shaking his head. No other active issues are obtainable at this time.

Past Medical History
1. Recent CVA.
2. Parkinson's disease.
3. Diabetes mellitus type 2 on insulin, diagnosed 1980s.
4. Essential hypertension.
5. Bulbar weakness with severe dysarthria and upper extremity weakness, 2006.
6. Degenerative joint disease.
7. GERD.
8. History of asthma.
9. Nonverbal secondary to recent CVA with Parkinson's.

Past Surgical History

1. Appendectomy.
2. Trigger finger release.
3. Bilateral carpal tunnel release.
4. Sinus surgery, 1990s.

Medications

VERIFIED AS ACTIVE IN MEDICATIONS MANAGER:

Acetaminophen (Tylenol®), by mouth as needed 2am 3 hs
AmLODIPine 10 mg Tablet, 1 Tablet(s) by mouth once daily
Aspirin, by mouth 81 mg 1 daily
Beclomethasone Dipropionate (Qvar®) Inhalation 80 mcg/Actuation Aerosol, 2 Puff(s) twice daily
Chlorhexidine Gluconate Mucous Membrane 0.12 % Mouthwash, 15 Milliliter(s) by mouth up to twice daily
Finasteride 5 mg Tablet, 1 Tablet(s) by mouth once daily
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100 unit/mL Insulin Pen, subcutaneously 4units breakfast, 0-2 units lunch, 11 units dinner, +SS max daily dose = 30units
Insulin NPH Human Recombinant (Humulin N KwikPen®) Subcutaneous 100 unit/mL (3 mL) Insulin Pen, subcutaneously 18 units am,18 units pm
Irbesartan 150 mg Tablet, 1 Tablet(s) by mouth once daily
Omega-3 Fatty Acids (OTC) (Natural Fish Oil®), by mouth 1000 mcg daily
Omeprazole 20 mg Capsule, Delayed Release(E.C.), 1 Capsule(s) by mouth once daily
Simvastatin 20 mg Tablet, 1/2 Tablet(s) by mouth once daily
Spironolactone 25 mg Tablet, 1 Tablet(s) by mouth once daily
Tamsulosin 0.4 mg Capsule, Sust. Release 24HR, 1 Capsule(s) by mouth once daily

Allergies

Hydrochlorothiazide: possible pancreatitis
Liraglutide Subcutaneous (Victoza 2-Pak®): Nausea

Family History

Pertinent for unknown cancer in his father who passed away from his disease. His mother had diabetes mellitus type 2, arthritis and hypertension. She is also deceased.

Social History

The patient lives at home with his son. The patient is retired from Smith and Foster. No history of tobacco, alcohol or illicit drug use or abuse.

CODE STATUS:
DNR.

Review of Systems

Review of systems could not be obtained due to patient condition.

Examination

VITAL SIGNS: Temperature 97.6, blood pressure 159/105, pulse 118, respirations 22, O2 saturation 93% on 2 liters.
GENERAL: Cachectic Caucasian male, nonverbal, disheveled appearance.
SKIN: The patient has abrasions on the right periorbital temporal region. Discoloration around the perioral region as well from emesis in the past. Multiple nevi in posterior back.
HEENT: Head: The patient appears to have a suffered a closed-head injury with bleeding on the right temporal region. Normocephalic. Ears: No tenderness or discharge. Auditory acuity cannot be assessed due to patient condition. Nose/sinuses: No inflammation of the nasal mucosa/septum/turbinates. Maxillary and frontal sinuses are mildly tender. Posterior pharynx and oral mucosa are dry.
BACK: Limited examination due to decreased range of motion.
HEART: Barely audible S1, S2. Mild systolic murmur appreciated left sternal border.
LUNGS: Diminished lung sounds diffusely. Mild expiratory wheezes on the right base.
ABDOMEN: Bowel sounds in all 4 quadrants. No rebound, guarding or hepatosplenomegaly appreciated.
MUSCULOSKELETAL: Decreased range of motion and physical deconditioning. Atrophy in muscles diffusely.
NEUROLOGICAL: Limited examination due to patient condition. The patient is nonverbal. Reflexes in the triceps, biceps, brachial radialis are 2/4 bilaterally. Negative Babinski. Cerebellar and finger-to-nose test grossly intact.
PSYCHOLOGICAL: Limited examination due to patient condition. The patient appears to have mild dementia.

Laboratory/X-Ray

WBC 20.3, hemoglobin 17.6, hematocrit 48.4, platelet 204, MCV 92.9, RDW 12.3. INR 1.2. Troponin I less than 15. ABG 7.36/46/74/26. Sodium 135, potassium 4.1, chloride 197, bicarb 26, BUN 45, creatinine 1.27, calcium 9.5. Blood glucose 559. Alk phos 117, ALT 55, AST 32. Magnesium 1.5. TSH is 0.98, free T4 1.5. Urine drug screening negative. Blood alcohol less than 20.

Radiology:

Portable chest, 1 view, image reviewed by myself reveals possible right lower lobe infiltrate. Poor inspiratory effort. Loops of bowel noted in thoracic cavity, possibly due to angle.

CT head without contrast obtained on 4/7/17:
IMPRESSION:
No intracranial hemorrhage or other acute abnormality by CT.

Cervical spine with an without contrast obtained on 4/7/17:
IMPRESSION:
No acute findings on cervical spine.

CT maxillofacial with and without contrast obtained on 4/7/17:
IMPRESSION:
No facial fracture identified. Superficial metallic debris along the right cheek and adjacent to the right

anterior globe. Extensive periodontal disease with absent right-sided maxillary and mandibular teeth.

Impression

1. Hyperglycemic hyperosmolar syndrome.
2. Suspect sepsis secondary to aspiration pneumonia.
3. Closed-head injury.
4. Leukocytosis secondary to #2.
5. Uncontrolled hypertension.
6. Acute hypomagnesemia.

Plan

The patient is admitted to the acute care unit, DNR code status, guarded condition as inpatient.

1. Hyperglycemic hyperosmolar syndrome. The patient is started on insulin per HHS protocol. We will readjust his insulin pending clinical course. He will receive normal saline IV fluids running at 100 mL per hour. Cautious use of IV fluids due to concern for volume overload.
2. Suspect sepsis secondary to aspiration pneumonia. The patient meets sepsis criteria with leukocytosis, tachypnea and tachycardia. Chest x-ray demonstrates possibility of pneumonia. The patient silently aspirates due to dysphagia. He is started on IV Vancomycin and Zosyn. No fevers are appreciated at this time. IV fluids are being provided as mentioned above. Will deescalate antibiotics pending cultures.
3. Closed-head injury. The patient sustained a laceration/abrasion on the right periorbital temporal region after being tackled by police. Extensive imaging of the head did not demonstrate any significant findings but we will monitor at this time. Wound care nurse has been consulted for dressing changes.
4. Leukocytosis secondary to #2. WBC is elevated at 20.3. He is provided IV fluids and IV antibiotics as mentioned above.
5. Uncontrolled hypertension. Blood pressure is elevated at 159/105. This might be due to the acuity of his presenting symptom. We have restarted his home medications and will readjust if it remains elevated.
6. Acute hypomagnesemia. The magnesium is 1.5. The patient will be given 2 grams of magnesium sulfate via IV 1 time. Repeat magnesium level in a.m.

DVT prophylaxis with Lovenox 40 mg subcu daily.
GI prophylaxis with home medication Omeprazole 20 mg p.o. daily.

Dr. Steven Brooks will assume care in a.m.

Justification for inpatient admission. This patient presents with hyperglycemia hyperosmolar syndrome with blood glucose of greater than 500 requiring insulin. There is also suspicion of sepsis from aspiration pneumonia. He is on IV Vancomycin and Zosyn. Will likely require at least a 2 midnight stay.

Patient care time 120 minutes reviewing patient chart, labs, examining patient, discussing with patient and hospital staff medical care plan.

*** COPY ***

Trung Tran DO/se/lja
Hospitalist

Dictated: 04/07/2017 at 23:41
Transcribed: 04/08/2017 at 01:22

EC:
Steven R Brooks MD

Electronically signed by Tran, Trung DO on 04/13/2017 22:24.